ETHICAL ISSUES IN PUBLIC HEALYH EMERGENCIES

* Recent public health emergencies
  + Inhalation anthrax from bioterrorism
    - Prophylactic antibiotics were offered to DC congressional staff within hours of exposure to anthrax but the antibiotics were delayed for the post office workers. Concerns were raided that working class, predominantly African Americans postal workers, received less timely prevention than predominantly Caucasian congressional staff. After that incidence many people showed up to the ER w/ URTI symptoms and cipro (the recommended drug for inhalation anthrax) prescriptions increased and there was a shortage
  + Smallpox vaccination in response to bioterrorism
    - In 2002 the CDC developed plans for smallpox vaccination of first responders to an outbreak. At first the union for EMT’s pressed for vaccination of the families of EMT’s arguing that they could be exposed to smallpox through clothing worn by EMT’s however this was rejected because the vaccine was in limited supply and because of risks to immunosuppressed third parties. The vaccination of first responders fell short of target levels because of the risk of cardiac adverse events.
  + Severe acute respiratory distress syndrome (SARS)
    - 2002-2003 SARS epidemic illustrated how emerging infections may spread rapidly from country to country through international airplane travel. Different countries have different public health responses.
  + Extremely drug resistant Tb
    - Patient with extremely drug resistant Tb went to Europe after being advised not to. He was on several flights and upon his return to the US a federal isolation order was issued. Lot of airlines and passengers had to be contacted in many different countries.
* How are ethical issues in public health different
  + Focus on population Outcomes
    - Public health is utilitarian; its goal is to improve aggregate measure of community health, like ↓ risk of SARS, XDR-TB, or pandemic influenza or ↓ mortality from these diseases.
  + Individual liberty and autonomy may be overridden
    - The government has the authority to impost mandatory public health measures in response to serious threats to the public. Under the Model State Emergency Powers Act, which 38 states have adopted in whole or in part, the state governor may authorize quarantine after declaring a public health emergency
      * Quarantine restricts the movement of persons who have been exposed, or might have been exposed to a communicable disease in order to prevent transmission during the incubation period
      * Isolation separates a person known to have a communicable disease from other people, during the period which he can communicate the disease to others.
    - People who get detained have their freedom restricted, their privacy violated, they suffer economic loss
    - In addition, mandatory medical interventions may be imposed, such as testing, vaccination and treatment.
    - Justification for violating patient autonomy is to protect the public good. Mandatory public health measure may be enforced by the state’s police powers.
    - Public officials should observe several requirements when imposing mandatory interventions in response to a serious and probable harm to the public health. These guidelines include:
      * The threat to public health must be serious and likely
      * The interventions should be effective in addressing the threat
      * The intervention should be least restrictive alternative that addresses the threat
      * Procedural due process should be available to persons deprived of their freedom and autonomy. Persons who are subjected to compulsory measures should have the right to an open, impartial and timely appeal of their case.
      * Equitable implementation of mandatory policies. The benefits and burdens of the intervention should be equitably distributed across society, consistent w/ the epidemiological features of the threat. In the past, public health measures were sometimes applied in a discriminatory manner against groups who were already marginalized, and persons and groups affected by epidemics often were stigmatized. However, no group should bear an unjust share of the burdens of the public health interventions or gain an unjust share of benefits. Even the perception that some groups are being treated unfairly will undermine public support for compulsory measures
    - Isolation and quarantine raise difficult social, financial and logistical challenges so they usually don't use those measures.
  + Change in the physicians role
    - Physician has less decision making power in a public health emergency. Public health policy during emergency are set by public health officials. If doctors disagree with these policies they should raise their complaints to the officials rather than take it on themselves to override guidelines.
  + Weaker evidence base
    - Evidence for interventions in public health emergencies often is weaker than the evidence base for clinical practice.
* Requests for non-recommended interventions
  + Doctors will encounter patients who reject restrictions on their autonomy as unwarranted or unfair.
  + During a public health emergency it may not be feasible, like would be in clinical practice, to provide interventions that are in short supply to persons who fall outside public health criteria for receiving the intervention.
  + Protect the public health
    - Doctors obligation during a public health emergency is to act for the common good.
  + Follow public health guidelines for allocation and triage
    - Allocation for influenza vaccine in the US is first it is given to persons needed to respond to the pandemic and then to those at highest risk
    - The priorities have a utilitarian rationale, to save the greatest number of lives during the public health emergency by giving priority to those at greatest risk of dying. Patients who have a poor response to the vaccine are excluded (like nursing home or immunosuppressed patients)
    - All human lives are valued equally
    - Some ppl propose life-cycle allocation procedure during emergency—this puts children at the highest priority and elderly at the lowest priority.
    - Physicians and public health officials should expect that many persons who are not in the high priority groups will request vaccination.
  + Perceptions of fairness
    - Any perception that public health measures are implemented unfairly will undermine trust in public health officials and willingness to accept restrictions.
  + Act in the best interest of the patient
    - Advocate for appropriate exceptions to restrictions
      * A particular case may be a justified exception to public health policies or may show that a policy needs to be modified.
      * Physicians should clarify how strict public health guidelines are to be enforced
    - Elicit and Address patient concerns and emotions
      * Physicians should acknowledge the uncertainty inherent in an emergency. Trying reassure people by telling them not to worry wont be effective.
      * Doctors may be able to address the patient’s concerns and needs without violating public health guidelines—EX: During an anthrax outbreak, in a patient w/ a high risk for anthrax occupation, a doctor could prescribe a different antibiotic other than cipro that may be effective and isn’t in short supply.
    - Use the doctor-patient relationship to benefit patients
      * During SARS epidemic, patients often could be reassured if they believed they could see the doctor promptly if their condition worsened or failed to improve. Also patient may be reassured by knowing what warning signs to watch for.
* Refusal of public health interventions
  + In emergencies individual autonomy is not paramount. Compulsory measures may be imposed to prevent transmissions to other and to control an outbreak of a serious infection.
  + Follow public health guidelines
    - In some situations doctors may have little control over public health measures.
    - Some measures are voluntary rather than mandatory where the physician must exercise discretion
  + Act in the best interest of the patient
    - Advocate for changes in guidelines or exceptions
      * Doctors should communicate any disagreement w/ public health guideline to responsible officials.
      * Justifications for exceptions need to have a sound public health basis.
    - Establish common ground with the patients
      * When patients refuse public health measures, physicians can try to find areas of agreement.
        + Patient doesn't want to infect family
        + Business people have to worry about their reputation and if they fail to comply with public health guidelines and other people get sick it could reflect badly on them.
    - Migrate the risk of mandatory public health interventions
      * Physicians can make patients in isolation or quarantine feel better about their situation by keeping in touch with the patient via telephone and addressing their feelings of isolation.
  + Refrain from deception
    - Patents may ask doctors to intentionally misrepresent their condition to exempt them from public health policies.
    - If doctors intentionally mislead public health officials then they cannot be trusted to tell the truth.
* Refusal to care for contagious patients
  + During epidemic or emergency situation doctors and health care providers may be at increased risk for getting the disease.
  + Some health care workers may refuse care for patient because of fears of contracting a fatal illness.
* Summary
  + In public health emergencies, time for physicians to deliberate about a particular case may be limited
  + Before a crisis occurs, physicians should think through in advance how they would respond to foreseeable dilemmas arising when patients disagree with public health recommendations or requirements.

PAPER

Case: 34 y/o male came to ED complaining of 7-12 loose, watery stools daily for the past 3 months. He had other nonspecific symptoms and reported previous IV drug use and a history of unprotected homosexual activities while in prison. He also had multiple unprotected sexual encounters w/ prostitutes. Now he is married w/ a 1 y/o child. He and his wife do not use protection. PE showed oral candidiasis. HIV test was ordered w/ the patients verbal consent. Patient later changed his mind about the HIV test and an order to cancel the HIV test was put in. The test was done anyway and it came back positive.

Ethical Dilemmas—Autonomy

* Right to know
  + Autonomy allows the individual to determine the degree to which he or she will participate, or not, in any specific activity, including health care. For a patient to exercise autonomy, he or she must have a degree of understands of his or her choice—therefore the doctors have a duty to inform the patient about possible dx and obtain informed consent for performance of indicated test. An ethical physician should engage in further discussion to assess the patient’s underlying lifestyle choices and situation.
* Right not to know
  + Physicians are obligated to discuss all diagnostic and therapeutic interventions w/ patients. Physician must also decide when to accept implied consent and when full documented consent is required. When obtaining informed consent that physician must consider the patient’s competence level. The risk of having an HIV test is unique in that it doesn’t involve end of life issues or really involve some risk of adverse outcome. The risks to the patient of a positive HIV test are of a social and psychological nature—it can lead to loss of support from family or friends, depression, broken relationships, and myriad other problems that could have tremendous impact on the patients personal life. HIV tests have been given a special status that is not afforded other basic medical tests in our country. Prejudices previously associated w/ HIV have become far less common.
  + Some physicians believe that it is inappropriate to order HIV tests in the ED for patients who will not be admitted due to the need for pre and posttest counseling.
* Resolving the problem
  + The patient described above had a sudden change of mind in the ED regarding the HIV test. This suggests an emotionally laden, perhaps uninformed decision. May be further discussion the patient would have wanted to know his HIV status. Because the test was performed and was done on the patients body and will be part of the patient’s medical record it could be argued that the patient should be contacted and told the results. This would preserve the patient’s confidentiality and the patient would be able to digest and divulge the information as he deems necessary, thus maintaining the patient autonomy. This supports the idea the beneficence overrides patient autonomy. The patient’s wife and child may be infected and a delay in dx may worsen complications. There is a legal basis that physicians have an obligation to inform such parties.
  + Another option in this case is to ignore the test results. Most physicians would probably disagree with this choice, realizing that it is in the patient’s and his family’s best interest to know this information regardless how it was obtained.
  + ER physicians must be up to date with state and local reporting obligations for various infections. Even if the physicians does not contact the patient, the doctor would still be required to inform the proper health authority to most jurisdiction
* Conclusion
  + The patient returned to the ED and received the letter than the ED had previously sent to him. He was admitted to the hospital when he came back in because he had deteriorated.